

# PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

## ***North Dakota—Supporting Family Caregivers with Payment for Services***

### **Issue: State Funds Used to Pay Spouses and Other Relatives**

#### **Summary**

As a rural state with a high elderly population and a low unemployment rate, the State of North Dakota faces particular challenges in offering home and community-based services. North Dakota, as part of its efforts to increase alternatives to nursing homes, uses state funds to provide monthly payments to spouses and other family members to care for low-income people with disabilities, including older people living at home. State staff believe the family payments are cost effective, although no formal evaluation has been conducted.

#### **Introduction**

North Dakota is an exceptionally rural state with low unemployment. According to 2000 Census data, North Dakota has 9.3 people per square mile, less than one-eighth the national average. North Dakota also has a low unemployment rate, currently less than 3 percent. These characteristics increase the difficulty of providing home and community-based services (HCBS) for people with disabilities. Meanwhile, the state's proportion of people age 85 years and older is almost one-and-a-half times the national average, increasing demand for HCBS.

One of many mechanisms the state uses to expand HCBS is Family Home Care (FHC), state-funded payments to family members to

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provide care to a person who may otherwise be eligible for nursing home admission. This report

describes FHC and how it is related to North Dakota's other publicly funded HCBS options. It also explains how FHC operates and the results to date. It is based on written materials produced by the State of North Dakota and interviews with state staff that administer the program.

#### **Background**

North Dakota offers three HCBS funding programs. FHC is one service option in two of these programs, Service Payments for Elderly and Disabled Program (SPED) and Expanded Service Payments for Elderly and Disabled Program (ExSPED).

SPED is the largest HCBS program in North Dakota, and started in 1983. FHC became available through this program in 1984. State general funds cover 95 percent of SPED costs and counties match the remaining five percent. SPED pays for a variety of services, such as adult day care, adult foster care, personal care, and homemakers as well as FHC. In order to qualify for SPED assistance, one must have liquid assets of less than \$50,000, and have been impaired for at least three months in four Activities of Daily Living or five Instrumental Activities of Daily Living. SPED served 2,044 people in calendar year 1999.

ExSPED began in 1994. The program is entirely state-funded and serves people who are not as functionally impaired as persons in SPED or in a Medicaid HCBS waiver. ExSPED is designed to prevent institutionalization in what North Dakota calls "basic care facilities", which are licensed by the state to provide less intensive care than a nursing home. ExSPED participants must have health or safety needs that may require

residency in a basic care facility, or be impaired in three of the following four Instrumental Activities of Daily Living: meal preparation, housework, laundry, or taking medications. ExSPED's available services are similar to services available through SPED. It served 242 people in calendar year 1999.

The Medicaid Waiver for the Aged and Disabled began in 1983 and covers most services available through SPED. Medicaid regulations prohibit payments to spouses and parents of minor children, so the waiver does not include FHC. Some 347 people used the waiver in calendar year 1999.

Before 1996, North Dakota had significantly higher nursing home utilization than the rest of the country. A 1996 state Task Force Report on Long Term Care Planning reported that North Dakota had 76 nursing home beds per 1000 people age 65 or older, compared to a national average of 50 beds. It also reported that the state had an occupancy rate of 95.6%, the second highest rate in the country.

North Dakota has taken steps to reduce nursing home utilization. These steps include increased funding for HCBS and a moratorium on nursing home beds. Between state fiscal years 1996 and 2000, Medicaid nursing home utilization decreased 12%, while publicly funded HCBS utilization increased 29%. Between state fiscal years 1996 and 1999, the number of people using FHC increased 17%.

### Intervention

Like other North Dakota HCBS services, applications for the Family Home Care program are administered through the county social services office. Participation in FHC has additional criteria besides participation in SPED or ExSPED.

**Monthly payments currently range from a low of \$186 to the maximum amount, \$700.**

First, the caregiver must meet state's definition of a blood relative (i.e. be a spouse, brother, sister, adult child, sister or brother-in-law, or ex-sister or brother-in-law). In addition, the person

and the family member care provider must reside in the same home.

If the person and caregiver qualify for FHC, the family care provider enrolls as a program provider and receives a provider number. North Dakota pays the family member on the basis of a daily rate and the number of days care is provided in a given month. The daily rate is calculated by a point-based formula derived from a formal assessment of need, where additional needs result in additional points. At the end of each month, the caregiver completes and submits a billing form. Monthly payments currently range from a low of \$186 to the maximum amount, \$700. The maximum amount is far less than the average monthly cost of institutionalization, approximately \$3200.

Two common concerns about paying family members are the quality of care and the possibility of fraud or financial abuse. Like all SPED and ExSPED services, North Dakota monitors the quality of FHC using consumer satisfaction questionnaires and case manager reviews. The state conducted consumer satisfaction surveys of a random sample of participants in 1998 and 2001. The surveys are not used to produce an aggregate measure of satisfaction (i.e., 95% satisfied), but state staff report the results were positive and did not indicate changes in current policies and procedures were necessary.

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The state monitors fraud and abuse through oversight of case management agencies, ensuring people are eligible and that the services provided are in fact needed. The state randomly visits FHC participants to confirm that the caregiver is in fact at home providing care.

### Impact

FHC served 407 people in state fiscal year 1999, less than one-fifth of all people using SPED and ExSPED. Forty percent of FHC providers are spouses, who could not be paid by Medicaid. State staff believe FHC is contributing to its goal of reducing the number of institutionalized

elderly. Anecdotal information suggests FHC enables family members to stay at home in order to take care of a relative, which might not otherwise be financially viable. This may not always be the case, however. FHC may simply compensate caregivers for what they were already doing, increasing the state's costs. The state has not conducted a formal study to determine whether FHS is cost-effective.

**Some Discussion Questions:**

**When paying family caregivers, to what degree does the state pay for help that would have been provided anyway?**

**Is compensation for family caregivers more likely to be cost-effective under particular circumstances, like a short supply of formal paid caregivers?**

**Contact Information**

For more information about the Family Home Care program contact Nancy Shantz, Program Administrator for Family Home Care at 701-328-8911 or [soshan@state.nd.us](mailto:soshan@state.nd.us). The web site for North Dakota's HCBS programs is <http://lnotes.state.nd.us/dhs/dhsweb.nsf/ServicePages/AgingServices>.

One of a series of reports by The MEDSTAT Group for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series will be available online at CMS' web site, <http://www.cms.gov>. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.